

THE NAVY PSYCHOLOGIST

SPOTLIGHT ON CLINICAL SERVICES

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FROM THE EDITORS

Greetings Navy Psychology Community, and welcome to the latest edition of *The Navy Psychologist - Spotlight On Clinical Services*. In this edition, we highlight work in a variety of clinical arenas, including primary care-based behavioral health, substance abuse treatment, pediatric psychology, and work with submariners and undersea mental health - a new "sub-specialty," if you will! Our Assistant Specialty Leader also offers us some compelling advice on building and maintaining clinical practice in High Reliability Organizations.

LT Morrison here - it has been a sincere pleasure to serve as co-editor over the last two years, and it is with great satisfaction that I step out of the saddle and hand the reigns to LT Kyle Bandermann for the next 4 issues. You'll see his contact information in the upcoming call for contributions, which is always just around the corner. Our next issue will focus on students, mentoring, and issues facing early career psychologists. So keep your eyes to the periscope for that announcement and have your ideas and achievements ready!

Happy Reading,

CDR Arlene Saitzyk
LT Jay Morrison

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MESSAGE FROM THE SPECIALTY LEADER: 200 in 2016!

Clinical psychology just hit another milestone. We now have over 200 active duty psychologists in the US Navy. This is paired with the 200 billet milestone we reached over a year ago. This success is a testament to the outstanding work each and every one of you do every day across the globe. The vast majority of these new billets are in the embedded mental health and operational arenas. More and more, line leaders are seeing the crucial value psychologists bring in helping them execute their missions. Adding to the carriers, infantry Marines, Naval Special Warfare, and Marine Corps Embassy Security Group, we are gaining billets in the submarine community, Marine Logistics Group, Joint Special Operations Command, Naval Expeditionary Combat Command, and Naval Special Warfare. And more are on the way. Many thanks go to CDR Joe Bonvie, the Operational Psychology Subspecialty Leader, for his tireless work. We continue to bring in outstanding psychologists and our community may hit 100% manning soon. The future looks bright for a diverse, impactful, and exciting career as a Navy Psychologist.



Clinical Psychology Specialty Leader
CAPT Scott Johnston

In the midst of this great news, we have had three years of poor performance at the promotion boards. For example, this year we had an in-zone selection rate of 29% for both the CDR and LCDR selection boards. This is below the average for MSC and below our 10 year running average. These results have many of you understandably concerned about career longevity. In response, the Executive Committee chartered a Promotions Working Group chaired by CDR Hiller-Lauby. Her group provided their first report to the Executive Committee and you will be seeing specific action steps soon. The selection boards continue to promote the best records, not the best officers. Ensure you manage your record and consult with mentors throughout your career.

Navy Day was a huge success again this year. After the strong showing at NMC Portsmouth last year, we held Navy Day at NMC San Diego this year. We had 76 in attendance and awarded 402 free CEUs. Thanks to the outstanding presentations from our subspecialty leaders, working group chairs, CAPT Jones, LT Bandermann and LT Morin. You can find these PowerPoint briefs on our milSuite site. The week also included the Executive Committee meeting, Navy Day, COSC Symposium, Psychological Health Research Roundtable, and community dinner. This was also the first year that Social Work and Psychiatric Nurse Practitioners held Navy Days and we all participated in a group social. There was a wonderful mental health synergy and we had a lot of fun. Mark your calendars for the next Navy Day to be held in Washington, DC, on 2 Aug 17 in conjunction with the American Psychological Association Convention.

Communication is always a challenge since we are geographically detached. I encourage you all to stay connected with our vibrant community. Please ensure you are on the listserve to receive important information. Visit our milSuite site, hosted by LCDR Johnson, and update your contact information on the roster and view important documents. Also, follow us on Facebook and attend the Town Hall meetings. Finally, read the informative TNP thanks to the efforts of CDR Saitzyk and LT Morrison.

It is time again for the Psychologist Survey. Once approved by BUMED, I will circulate the link and encourage you all to participate. These results will be the driving force for our new Future Directions Working Group and subsequent 2017 Strategic Plan.

As 2016 begins to wind down, please start thinking about your nominations for the 2016 Senior, Junior, and Civilian Psychologist of the Year. I will officially call for nominations soon.

I am wrapping up the plans for the remainder of the 2017 PCS moves. If your PRD is in 2017 and we haven't figured out where you are going next, please make sure you contact me soon. I have transitioned to my new day job. My new contact info:

Email: scott.johnston@socom.mil

Desk Phone: 619-537-1588

Clinic Phone: 619-537-3280

It is such an honor to be your Specialty Leader. This past year, I have had the pleasure to meet with many of you as I traveled around the world with the Behavioral Health Data Portal (BHDP) implementation. It is inspiring to hear about all the wonderful initiatives you are involved in and I appreciate all the hospitality. I continue to be impressed by the caring, passion, and dedication I observe in our community. As I met with your various COs, I hear over and over again about the positive impact you all have with your patients, the command, and Navy Medicine. Thank you for all you do. Ψ



CAPT Johnston addresses the Clinical Psychology community at Naval Medical Center San Diego.

MESSAGE FROM THE NATIONAL TRAINING DIRECTOR

DR. ERIK J. GETKA

CAPT, MSC, USN (Ret)

With the waning days of summer comes a whirlwind of hails and farewells. Graduating interns and post docs shed their trainee status, new interns, post docs, and Uniformed Services University of the Health Sciences (USUHS) students report for training, and new Health Professions Scholarship (HPSP) students eagerly await the direct deposit of their first scholarship checks. In the midst of all this activity, recruiting for next year's classes is gathering momentum.

In this installment of the National Training Director's Corner, I would like to do three things: give you a bird's eye view of who is graduating from and entering our training programs, highlight our recruiting goals for the 2017-2018 Academic Year, and introduce you to the new Chair of the Psychology Department at the Uniformed Services University of the Health Sciences. So, without further ado....

WELCOME ABOARD!

Between the first week of August and mid-September, 22 new accessions to Navy psychology began their training in the USUHS Ph.D. program, the Walter Reed National Military Medical Center, and Naval Medical Center San Diego internships, and the Portsmouth post-doctoral fellowship. Five others will join the rolls of our scholarship students. It gives me GREAT pleasure to present them to you!



USUHS Ph.D. Program in Clinical/Military Psychology	
Rebekah (Gwen) Gunter	Denison University
Kevin Wilfon	Texas A&M
Health Professions Scholarship Program	
Katelyn Desrosiers	William James College
Benjamin (Brad) Devore	Virginia Polytechnic Institute
Sierra Dimberg	Arizona State University
Jourdin Watkins	Midwestern University
Nicolette Youkhaneh	Loma Linda University
Doctoral Internship: Walter Reed National Military Medical Center	
Milton Dawkins	Jackson State University
Odelia McFadden	Philadelphia College of Osteopathic Medicine
Jessica Riley	Adler University
LaToya Small	Chestnut Hill College
Bryan Steinkopf	NOVA Southeastern University
Michael Widroff	Hofstra University

Doctoral Internship: Naval Medical Center San Diego	
Lyndse Anderson	Fielding Graduate University
Michael Greenberg	Wright Institute
Evelyn Knipe	Alliant University (San Diego)
Lea Lafield	University of Missouri
Lindsay Reinhardt	USUHS
Elizabeth Whipple	Drexel University
Doctoral Internship: Naval Medical Center Portsmouth	
Aaron Weisbrod	USUHS
Allison Conforte	USUHS
Elizabeth Bohm	Adler University
Rayna Herren	Wichita State University
Pony Ithanongsak	Alliant University (San Francisco)
Emily Hu	Seattle Pacific University
Post-Doctoral Fellowship in Clinical Psychology: Naval Medical Center Portsmouth	
Alicia Murray	Philadelphia College of Osteopathic Medicine
Elena Tillman	William James College
Melissa Dubey	Adler University

TRAINING PROGRAM ACCESSION GOALS FOR FISCAL YEAR 2017

USUHS Ph.D. Program: 2

HPSP: 5

Doctoral Internships: 12 (6 at Walter Reed National Military Medical Center and 6 at Naval Medical Center San Diego). Interns for the doctoral internship at Naval Medical Center Portsmouth come from the USUHS and HPSP programs and are not counted as new accessions.

Post-Doctoral Fellowship in Clinical Psychology, NMC Portsmouth: 3

Detailed information about all of our training programs can be found at <http://www.wrnmmc.capmed.mil/ResearchEducation/GME/SitePages/Psychology/Navy%20Psychology.aspx>

In addition to training program accessions, we will be recruiting 4 fully-licensed psychologists.

WELCOME TO THE FLEET!

We ask a lot of our trainees. Unlike their civilian counterparts, they must acquire not only the competencies of a clinical psychologist, but also the ability to function effectively as Naval officers. Either would be a major accomplishment in itself. Achieving both in a short 12 months is testimony to their resilience and determination. It is also testimony to the remarkable talent and dedication of our Training Directors and faculty members. The Navy owes all of you a deep debt of gratitude.

Please join me in congratulating the graduating classes 2016.

POSTDOCTORAL FELLOWSHIP IN CLINICAL PSYCHOLOGY, NAVAL MEDICAL CENTER, PORTSMOUTH

Congratulations Fellows! LT Stefan Schalk will serve next at Naval Medical Center, Portsmouth, VA, and LT Katheryn Ryan is off to Naval Hospital Okinawa, Japan.

**DOCTORAL INTERNSHIP, NAVAL MEDICAL CENTER, PORTSMOUTH, VA**

Congratulations Interns! From left to right, with first set of orders: LT Marcus VanSickle (Fort Belvoir Community Hospital, Fort Belvoir, VA), LT Cassandra Sieg (Naval Health Clinic New England, Groton, CT), LT Chantal Meloscia (Naval Medical Center, Portsmouth, VA), LT Wendy Rasmussen (Naval Health Clinic, Hawaii), LT Jackson Taylor (Naval Hospital Okinawa, Japan), LT Joel Snider (Naval Hospital Jacksonville, FL), and LT Ryan Reed (Naval Medical Center, San Diego, CA).



Dr. Mike Franks
CDR, MSC, USN
Training Director



DOCTORAL INTERNSHIP, WALTER REED NATIONAL MILITARY MEDICAL CENTER (WRNMMC), BETHESDA, MD



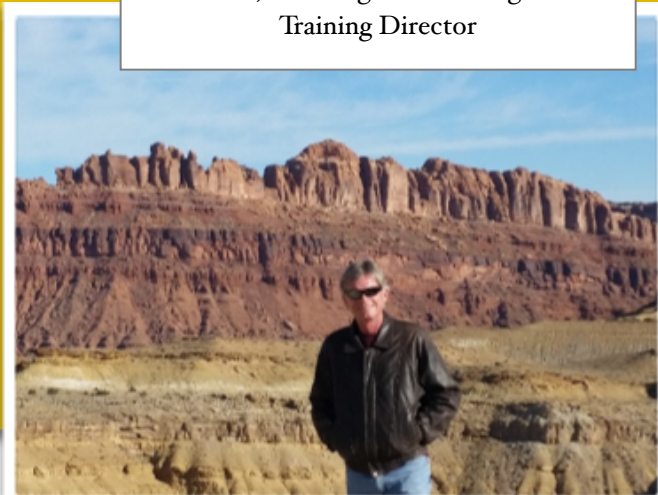
Dr. Richard Bergthold
CAPT, MSC, USN (Ret)
Training Director



Congratulations Interns! From left to right, with first set of orders: LT Linett Sierra (Naval Hospital, Guam), LT Shawna Rodriguez (WRNMMC, Bethesda, MD), LT Titus Hamlett (Naval Medical Center, Portsmouth, VA), LT Mark Palcan (Naval Hospital, Bremerton, WA), LT Kelsey Blomeke (Naval Hospital, Camp LeJeune, NC) and LT Sakshi Sharma (Naval Health Clinic, Cherry Point, NC).

DOCTORAL INTERNSHIP, NAVAL MEDICAL CENTER SAN DIEGO

Dr. Dave Mather
CAPT, MSC, USN (Ret)
(Aka, "The Sage of San Diego")
Training Director



Congratulations Interns! Front left to right, with first set of orders: LT Alyssa Garofalo (Captain James A. Lovell Federal Health Care Center, Great Lakes, IL), LT Grace Hamelberg (Naval Hospital, Pensacola, Fla), LT Yolanda Lawrence (Naval Hospital, Beaufort, SC) **Back left to right, with first set of orders:** LT Crystal Peterson (Naval Medical Center, San Diego, CA), LT Michael Croke (Naval Hospital, Naples, Italy), LT Eren Roubal (Naval Hospital, Camp Pendleton, CA).

NEW LEADERSHIP AT USUHS

Many of you will recognize Dr. David Riggs as the Executive Director of the Center for Deployment Psychology (CDP), a position he has held since 2006. On November 16th, 2015, Dr. Riggs accepted the position of Professor and Chair, Department of Medical and Clinical Psychology at USUHS.

When Dr. Riggs became the Executive Director of the CDP, it was a concept on paper. Under his strong leadership, it has become an innovative national resource dedicated to training mental health professionals to meet the unique needs of service members, veterans and their families. In addition to his appointment as Chair of the Psychology

Department at USUHS, Dr. Riggs has retained his position as Executive Director of CDP. Through some mysterious form of bilocation or self-cloning (and a knack for recruiting superb people to work for him) he is adroitly handling both jobs.

Dr. Riggs earned his Ph.D. in Clinical Psychology from the State University of New York at Stony Brook and has held academic appointments at Tufts University School of Medicine, Boston University School of Medicine, Saint Joseph's University, and the University Of Pennsylvania School Of Medicine. His extensive research and writing over many years has focused principally on PTSD and exposure therapy. He is a recognized expert in the treatment of PTSD with Prolonged Exposure Therapy.

Since the early 1990's, the Ph.D. program in clinical psychology at USUHS has produced a succession of highly-skilled and dedicated Navy psychologists. It is reassuring to know that this valuable resource is in the capable hands of Dr. Riggs. Ψ



From left to right: CMC Patrick Hyde (retired) and LT Melissa Strahan conduct a promotion ceremony for newly minted USUHS students! LTs Aaron Weisbrod and Allison Conforte, LTJGs Jared Bollinger and Viktor Koltko, ENS Julia Garza, and LTJGs Kyna Pak and Amy Lee.

**RESERVE SUPPORT: BACKGROUND & ADVICE FOR ACTIVE DUTY
PSYCHOLOGISTS**

CDR MICHAEL BASSO

Are you a one of one in a small clinic? Are you going to be gapped for coverage, and need to plug that hole? Are you intending to arrange for coverage with a reservist?

If so, my active duty brothers and sisters, this column is for you.

Reservists support the active duty in several ways. Perhaps the most common support occurs when the reservist arrives at your MTF on a set of Annual Training (AT) orders. AT is an entitlement; every reservist in a paid billet can expect to perform a two week period of active duty annually. Normally, at the beginning of the fiscal year, the reserve Command will identify AT priorities and will staff the requirements. If an AT requirement is not identified for an individual, the reservist takes initiative, and requests an AT through their operations officer. The reservist will offer periods of time that would be convenient, and the Command's operations officer works with the active duty Operational Support Officer (OSO) to identify an AT opportunity. AT is disbursed through the reserve center. This money is budgeted at the beginning of the fiscal year, and is obligated to pay for the reservist to perform active duty. Normally, most ATs are scheduled as early as March-April, but they must be scheduled no later than June.

Reservists may also support active duty Commands through Active Duty for Training (ADT) orders. This is money from BUMED. ADT is normally budgeted a year in advance, but BUMED typically possesses some limited discretionary funds to support urgent unanticipated needs. To tap into these funds, your Command must convince BUMED that you are facing a crisis, and reserve support is your sole best option.

There are 16 reserve psychology billets, but there are 20 reserve psychologists. Some of us are not occupying psychologist billets, and others are not in a paid billet (i.e., drilling for retirement points only). A paid billet means that the reservist gets paid for their drills, and they are assigned to provide active duty support to either an MTF or a reserve operational medical unit. For example, Balboa, Portsmouth, Bethesda, JAX, Pensacola and Bremerton have reserve psychologists assigned to them. Reservists in these billets are expected to perform AT at one of these commands or one of their subordinate satellites.

Regarding the operational billets, these involve Marine Corps units or Expeditionary Medical Facilities. Reservists assigned to these units normally perform their AT at a field exercise, and are not expected to provide support to an MTF. Consequently, there are essentially six psychologists who can be expected to support the MTFs. Those in operational billets or non-psychologist billets may be released to support an MTF, but that is not necessarily career enhancing for them. Those psychologists in unpaid billets do not receive an AT entitlement. If an urgent need arises, money is sometimes found for them to perform AT, but this cannot be expected.

The reserve units have operational control over their psychologists. They have the authority to direct the reservist to perform a period of AT. If your clinic falls under one of MTFs with an assigned reserve psychologist, arranging coverage for anticipated gaps will be relatively easy. Open a discussion with your OSO, and notify them of your need. The OSO will contact the operations officer of the reserve command, and the operations officer will reach out to the assigned psychologist to coordinate coverage. The OSO generates orders, the reservist arrives, and your gap is covered.



If you do not fall under one of the MTFs with an assigned psychologist, coordinating support is a bit more difficult. You can reach out to me, and I can canvass the reserve psychologists to determine availability. Interested psychologists must request permission from their Command operations officer to perform AT with you instead of their designated Command. If approved, you will provide information to the OSO from the reserve psychologist's Command. The OSO writes the orders, and your gap is filled. Otherwise, if your OSO is effectively networked, they might reach out to OSOs from other MTFs, and they could negotiate reserve support indirectly.

So, how do you make this work with minimal friction?

1. Start now. Time is the one commodity you can never replenish during your planning process. Talk with your staff, and identify potential gaps now.
2. Work with your OSO or the reserve specialty leader at the beginning of the fiscal year. This will increase your likelihood of success. If you wait until March, you will probably find it difficult to arrange coverage. If you wait until a month before your gap, you will likely achieve failure.
3. Remember that the reservists typically are not directed to perform AT at a specific time. Granted, the reserve Command can order the reservist to perform an AT at an arbitrary time, but this does not typically occur. The reserve psychologist has a civilian job, and normally must negotiate with their employer for military leave. Clinical coverage during their absence must be arranged. Lots of gears must turn in synchrony. The more advance notice that you give the reservist, the more likely they can take leave from their civilian job.
4. If an emergency occurs, and you find yourself suddenly gapped, work with your OSO. If reserve support is the only option, the OSO can contact BUMED and seek additional funding for ADT support.

In the past year alone, I've been able to facilitate coverage to three locations that have no designated reserve support. This worked because there was sufficient time to lubricate all of the friction points.

Bottom line-start working this issue now. Ψ

Reserve support! Reserve psychologist CDR Tim Murphy offers a helping hand to the USS THEODORE ROOSEVELT (CVN 71).



One-of-One Providers Unite! LT Jay Morrison, USS THEODORE ROOSEVELT, LCDR William Blair, USS CARL VINSON, and LT Nathan Hydes, USS NIMITZ, supporting the psychological needs of their strike groups alone and unafraid!

Erratum: Last issue, CDR Robert Obrecht was listed as the first psychologist assigned to a carrier, with CAPT Maggie Lluy as the first psychologist assigned permanently to ship's company. LT Brian Hershey was actually the first psychologist assigned to a carrier, aboard the USS ABRAHAM LINCOLN in 2000.

NAVY CLINICAL PSYCHOLOGY: A HIGH RELIABILITY COMMUNITY

CAPT SHANNON JOHNSON

By now, many of you have heard Navy Medicine is on a journey to become a High Reliability Organization (HRO). If you are currently in a leadership role at a Military Treatment Facility, or plan to seek a leadership role anywhere within the organization, then I encourage you to become an HRO champion and an expert in the HRO principles.

The principles of an HRO are not unique to Navy Medicine. The airline and nuclear power industries have led the way with developing cultures grounded in HRO principles. Anyone who has spent time in the medical department on an aircraft carrier, sandwiched between round the clock flight deck operations and two nuclear power plants, has benefitted from the culture of safety that is the hallmark of an HRO.

High reliability organizations are learning organizations where every member, no matter how seasoned, well trained, and experienced, accepts that human infallibility is impossible. HROs rely on collegial, interactive teams, whose members are committed to robust communication, catch and neutralize one another's mistakes, and seek to reduce variation. In an HRO even the most senior members welcome constructive feedback and encourage others to speak up to enforce standards and best practices.

What does this mean for Navy Psychology? Are we a high reliability community? How much variation is there between the way individual Navy Psychologists practice, such as in diagnoses given to a particular patient, military dispositions rendered, and recommendations made to the chain of command?

Often in my role as the Director of Mental Health, I have to review cases where a service member has been evaluated and engaged in treatment with several different mental health providers. Sometimes I note significant variation between the diagnoses and recommendations made by the different mental health specialists involved in the case. More concerning is that too often, I discover discrepancies between providers even when these providers are seeing the same patient during the same time period, for example, when a service member is being followed by both a psychologist and a psychiatrist. This makes me wonder whether the providers took the time to read each other's notes, and if so, why one of the providers did not reach out to the other clinician involved and make an attempt to resolve the discrepancy. I believe it is only through collegial case discussions, frequent consultation, and openness to constructive feedback that we will continue to make progress toward becoming a high reliability community.

If we want to be regarded as a community of competent professionals, each one of us must be committed to reducing variation, and willing to reach out to colleagues for consultation and resolution of discrepancies. Quite often, such consultations will lead to interesting and productive discussions that increase our own clinical competence, as well as those of our colleagues in psychology and the allied mental health disciplines. This can be as easy as picking up the phone to call another mental health provider to discuss a case when we recognize there is inconsistency regarding case formulations and military dispositions documented in the record.



Further, if you are an operational or embedded psychologist, such as a psychologist assigned to an aircraft carrier, and are asked to review a case of a service member being returned fit for full duty following a period of limited duty for a mental health condition, please do not push back on accepting the service member without first having a discussion with the mental health provider who treated the service member and deemed the individual fit for full duty. Similarly, providers evaluating service members in an MTF clinic should refrain from documenting that a member is unfit for duty without first consulting with the psychologist at the member's operational command when applicable. The embedded psychologist may believe the member is still able to function effectively in the operational environment and can provide relevant collateral information based on direct observations from operational work center supervisors, department heads, and commanding officers. This will ensure that clinical decisions in clinic settings and operational settings are being made using same sets of observations regarding the patient. I realize that it takes time to have these collegial conversations, but in my experience, being proactive in these cases reduces the administrative burden in the long-run. When we have one psychologist saying a member is fit for full duty and another psychologist makes the determination the same member is unfit, this causes both the line and medical leadership to doubt the credibility and reliability of our profession. More concerning, it is unfair, confusing, and harmful to our patients. We owe it to our patients, to each other, and to our community to provide clarity and seek to reduce the variability.

Please keep in mind that the peer consultations that serve as the bedrock of an effective HRO, hinge on an assumption of collegiality, humility, and openness. When you initiate a conversation about diagnosis or disposition with another professional, or when another professional reaches out to you for the same, do your best to check your ego and quite natural tendency toward defensiveness at the door. Remember the first rule of communitarian ethics: a professional can only be truly competent in the context of a caring reciprocal community of colleagues. Maintain a learning orientation and view each of these conversations as a gift. In the end, it's all about our patients, not us. Similarly, a robust peer review process is vital for HROs. The purpose of peer review is to improve psychologists' clinical skills and ensure provision of high quality patient care as part of psychologists role as healthcare providers. Peer review is not meant to be punitive, but to help psychologists improve our clinical skills and the care we provide to our patients.

Finally, a question that often comes up when discussing what it means to be an HRO is – what is the difference between Best Practices and Standard of Care? Psychologists strive to utilize best practices, but at a *minimum* all clinical activities should meet the standard of care. Standard of Care, a legal term, can be described as the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstance. This concept represents a minimal level of competent practice in a given profession and setting. Typically, violations of standard of care are practices that are likely to result in patient harm. As an example, failing to assess suicide risk during an emergent patient evaluation could be considered a violation of a standard of care. A Best Practice is a procedure that has been shown by research and experience to produce optimal results and that is established or proposed as a standard suitable for widespread adoption. In clinical psychology, these include such things as utilizing a detailed and validated suicide risk assessment such as the Columbia Suicide Rating Scale (C-SSRS), evidenced based treatments (Cognitive Behavioral Therapy, Cognitive Processing Therapy, Prolonged Exposure), and objective criteria (e.g., GAD-7, PHQ-9, PCL-5) to measure outcomes. The American Psychological Association has a number of guidelines for best practices (<http://www.apa.org/practice/guidelines/>). I recommend these to you for consideration.

Please join me in a commitment to the principals of an HRO, and to the goal of becoming an increasingly competent community. Let's be a community that welcomes and encourages collegial discussions and the seeking of consultation, and whose members value and effectively engage in the peer review process. While a hallmark of being an HRO is a willingness to be transparent about the opportunities for improvement, this should never detract from the sense of pride we feel for the extraordinary service we provide in support of vital operational missions around the globe every day, and the critical skillset we bring to the fight. In both my role as the Direct of Mental Health and as the Assistant Specialty Leader, the feedback I receive about our community is overwhelmingly positive. Navy Psychology is among the most well respected and valued communities in the Navy. Let's all do our part to protect our hard earned, well deserved reputation.

For more information on the application of HRO principles in a healthcare setting, please see: <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care> Ψ

**SUMMARY REPORT: WORKLOAD AND PROVIDER BURNOUT
WORKING GROUP**

LCDR MICHAEL CONNER

Following the Navy Psychology Needs Assessment Surveys (NPNAS) in 2012 and again in 2014, the Executive Committee (EXCOM) directed the establishment of working groups to explore identified areas of concern and develop prospective solutions. Our committee, the Workload and Provider Burnout Working Group, was chaired by myself, and included CDR Arlene Saitzyk, Dr. Scott Berry, LCDR Katherine Pierce, LT Adrienne Manasco, and LT Nazia Rahman. Our target from the NPNAS findings was that a subset of our community reported higher than average levels of emotional exhaustion, significant distress, and burnout.

Our working group collaborated several times a month via email and teleconferencing to discuss our mission, refine our scope, and develop a plan of action. It was apparent early on that more information was needed. In particular, the NPNAS did not include sufficient subgroup data (e.g., platform, organization, or type of work center) to readily identify if the subset reporting burnout was distributed throughout our community or confined to a few facilities. Because the assessment instruments used in the NPNAS did not provide data on certain factors often associated with professional burnout in a caregiver population (e.g., autonomy, flexibility, source of stress), we queried a targeted subset of providers from Military Treatment Facilities (MTFs) and their branch clinics, to better assess specific administrative variables potentially related to occupational fatigue. Notably, concerns about excessive workload resulted in the issuance of a guiding memorandum by the Psychology Health Advisory Board (PHAB) in 2013, recommending a maximum of 33 hours of direct patient care per week. We wanted to see how widely this recommendation was being followed and if there was a correlation with community burnout. We requested feedback on specific questions related to the administrative management of mental health clinics such as scheduling practices, template management, and workload expectations. We also asked for broader qualitative input on perceived functionality of workload and general feedback on workload and burnout.

Our findings were informative and relatively broadly applicable as we received input from 25 of 29 sites. As for the prior PHAB recommendations for 33 hours of direct patient care, our data revealed a median of 30 hours (mean of 28.6), squarely in line with the PHAB recommendations. Thus, overall there did not appear to be community-wide strain from total number of hours of direct patient care. That being said, 36 percent of respondents reported a belief that the workload within their clinic was NOT functional. So, if perhaps not from direct patient load, what are the other potential contributors to burnout? Themes from the qualitative feedback we identified centered on the following: lack of control or flexibility in managing schedules and templates, burdensome collateral duties and non-clinical administrative tasks, and excessive patient panel size and demand to retain all referrals within the clinic in spite of inadequate provider staffing, thus interfering with ability to follow clinical practice guidelines for quality care. These factors were the most strongly associated with qualitative reports of occupational burnout and decreased professional satisfaction.

While a narrow sample selection limits the generalizability of these qualitative findings (i.e., typically one respondent per site and only MTFs and branch clinics), it appears panel size and scheduling flexibility are two potential targets for action. Advocating for and implementing systemic changes are our group's next challenges.



Dr. Berry provided an excellent training at Navy Day in San Diego on working with your command's business office to learn how access to care is measured, request a business case analysis, and potentially obtain additional staffing. Briefly, during the Navy Day training he also suggested use of "Routine" slots for new patients, and requiring new patients be seen within seven days rather than within the 28-day standard for "Specs." This will allow the system to better recognize a problem of inadequate staffing if the next available slot is past seven days. Given the apparent effectiveness of the prior PHAB recommendations for limiting direct patient care hours, it is also reasonable that targeted recommendations for limiting panel size and encouraging flexible approaches to template management and scheduling may be equally instrumental in effecting change. There are already Navy mental health clinics that have succeeded in doing just this, with excellent results in provider satisfaction and adherence to clinical practice guidelines as evidenced by the positive qualitative feedback received from those sites. For example, clinics allowing significant provider autonomy in template management, while maintaining necessary workflow, reported the template flexibility as key to workplace satisfaction. Such flexibility allows for fluid management of collateral duties, administrative and leadership responsibilities, and case management for complex cases.

Our working group will be drawing upon this information to provide a point paper for the PHAB. Notably, one member of our committee learned that one of our sister services contracted with a university to study optimal provider panels, including discussion of what is an appropriate number of high, medium, and low risk patients. Our hope is that the Navy may draw upon these findings, as well as recommendations promulgated by the PHAB. In the meantime, it is always good to draw upon what we already know regarding self-care. As psychologists, we are very good at recommending this to others. As the research shows, to reduce stress, remember to maintain a sense of humor, engage in hobbies, spend time with your family and friends, work to balance personal and professional lives, and seek guidance and mentorship from others. The Navy Clinical Psychology FaceBook Page, the Mentorship Committee, your Specialty Leaders, and our working group are standing by to assist. Ψ



Preventing burn-out means making your needs known - in this case, for candy! Team JSMART at GTMO has their request met. Pictured here: LT Katherine Kline, LT Ashley Shenberger, LT Daniel Babskie, MSgt Terrence Bishop, HM2 Jonni Gillispie, HM3 Jon Goudreau, HM3 Keilsey Hodson, HM3 Kegan Keller, HM3 Blake Kemp, HM3 Bryan Lochan.

CULTURAL COMPETENCE: A CLINICIAN'S PROFILE OF US NAVY SUBMARINERS

LTs KYLE BANDERMANN, ALLISON CLARK, & DANIEL NORTHINGTON

One aspect of attaining cultural competence in clinical settings is an understanding of the population with whom one works. Within the military, this military culture with which we work toward competence is further stratified into the subcommunities (no pun intended). Marines are not Soldiers. Boatswain's mates are not pilots. Treating, educating, and advocating for members of each of these subcommunities is different based on our knowledge and conceptualization of "what makes them tick." The assumption of unique identity is certainly true for the newest community that is quickly opening its hatches to Clinical Psychology - the undersea world of submariners.

Until recently, "Wizards" have intentionally been kept out of the undersea community due to our much-maligned ability to make their Sailors disappear. "Skull mechanics," as we have more recently come to be known, have gained a huge appreciation from Skippers, Commodores, and Admirals down to Firemen Recruit. Since 2013, after taking on a psychiatrist, CDR James Rapley, and later one of our own psychologists, LCDR Mathew Rariden, Submarine Force (SUBFOR) leaders started to ask, "What more can you do for us?" An after action report spelled out their pilot program's strength and weaknesses, and strongly urged the Navy to continue to support submarine forces. Over the past three years, similar pilot programs have reached Submarine Group 9 under the leadership of LT Kathleen Wipf Saul in Bremerton, WA, and even the small, remote island of Guam and Submarine Squadron 15. What began as submariners being a primary client in the Mental Health Department (MHD) at U.S. Naval Hospital Guam has grown into an embedded provider on loan to Submarine Squadron 15. As we have seen with providers on aircraft carriers and Marine units, the desire for the subject matter expertise of Clinical Psychologists is growing.

As that demand grows, it is incumbent upon us to understand the culture within which we're embedded. We, the authors, have treated these submariners at the Undersea Mental Health Clinic (UMHC), have gone underway on fast-attack submarines, and have had open and frank discussions with line leaders about stress injuries, resiliency, and risk management. Here, we hope to give you a clinical glimpse into the profile of a typical submariner.

The "average submariner," while certainly prone to error just like other stereotypes, may present more

homogeneity than many other groups. He is, more than likely just that - male. While there are approximately 100 female submariners in the Navy, 100% of the crew on fast-attack submarines (the majority of our undersea assets) is male. The average submariner is also likely to be intelligent and Caucasian. About one third of submariners are "nukes," that is, nuclear-trained personnel who are even more likely to be male, intelligent, and Caucasian. The submarine force is also relatively young; many report to the submarine already with two years of service (due to the extended training pipeline), and a submariner can wear Chief's anchors as early as 25 years old.



If pilots are sometimes stereotyped as “narcissistic,” and infantry Marines as “antisocial,” then submariners can undoubtedly be labeled as “Cluster A.” Their decreased need for social interaction is unquestionably adaptive, given a lack of exposure to the above ground social world for six months at a time. Their often-uncommon interests, such as in nuclear fission, and their preference for facts versus emotions can paint a picture of self-reliance and low need for interdependence.

The average submariner is irreplaceable. Each man on a submarine, especially on a fast-attack, represents the concept of “one-of-three.” There are three men for each 24/7 job. While “days” are 18 hours long, each man works a six-hour shift, performs training (including extremely challenging testing for qualification) for another six-hour shift, and is then allowed a sacred six hours for sleep before he rinses and repeats. While a human factors scientist can readily see many opportunities for stress injuries under these conditions, the indispensable nature of each submariner becomes even more important when it comes to clinical disposition. This irreplaceability may foster a sense of personal importance and entitlement in some submariners. They know their role is unique, steeped in a history of clandestine operations and sometimes dangerous conditions, and they are held to an exceptionally high standard. In addition, they receive significant bonuses for their time served undersea - a coveted perk that reflects the significant quality-of-life sacrifice.

The average submariner is relatively healthy. Screening for submarine service - a volunteer only opportunity - is grueling. Submarine candidates are exposed to a host of potential stressors during training in order to assess and inoculate them against the potential stress reactions later. This becomes extremely important in treatment as well. A diagnosis seen by us as simple and commonplace as an Adjustment Disorder can be disqualifying if not fully remitted in 30 days and all psychotropic medications are immediately disqualifying. Thus, healthcare providers of submarine personnel need to proceed with caution. They must fully consider a Sailor’s level of functional impairment and proceed with intervention-focused diagnosis, that is, selecting a diagnosis, treatment plan, and disposition that are all cohesive. If, in your professional assessment, a Sailor would improve with short-term cognitive-behavioral skills, perhaps this isn’t an adjustment disorder, but merely an occupational problem. Conversely, if your assessment indicates a Sailor is not amenable to treatment, perhaps the best recommendation would be for separation from submarine service rather than engaging in disqualifying treatment, with which they may not be invested, and keeping a needed position vacant, thereby overworking the rest of the crew.

Whether advising Commanding Officers on human factors and offering industrial-organizational interventions, or intervening directly with a Sailor via clinical assessment, diagnosis, and treatment, it is clear that the opportunity for our subject matter expertise is ripe. Discussions between the Bureau of Medicine and Surgery (BUMED) and

SUBFOR are ongoing as the latter looks to purchase additional billets in the coming years. If you have the tenacity for difficult work, the desire to make an impact in a new community, and the creativity to make it your own, we encourage you to consider pursuing an assignment as an undersea psychologist. Ψ



BEHAVIORAL HEALTH INTEGRATION IN PRIMARY CARE

LT LINDSEY GLEASON

The utilization of Behavioral Health Integration in Primary Care (BHIP) in the military has produced numerous positive outcomes for patients, providers, and the military health care system overall. BHIP in its current form has been in existence in the Navy since 2010. The program was created to implement the Medical Home Port (MHP) and Department of Defense Instruction guidance for mental health care in the primary care environment.

BHIP is a consultative-based model of care with the goal of providing on-demand mental and behavioral health support to the primary care manager (PCM) to improve patients' overall health care. BHIP provides short-term, evidence-based interventions that focus on improving the health, functioning, and quality of life of the entire enrollee population.

Statistics show that nearly half of all people with a treatable behavioral health disorder do not seek care from a behavioral health professional. However 80 percent of these people *will* visit their PCM at least once a year (in the military healthcare system, this number is closer to 100%). Therefore, Department of Defense primary care clinics have expanded their focus to meet more patients' health care needs under one roof. Under this integrated approach, each patient works with a team of providers (physicians, nurses, pharmacists, behavioral health professionals, and others) to develop a comprehensive, personalized health care plan that addresses the physical, psychological, and social aspects of one's health. Unfortunately, the stigma associated with seeking behavioral and mental health treatment often prevents people from seeking out and subsequently receiving the care they need. BHIP helps to break down some of these barriers by bringing mental and behavioral health care to a familiar, non-stigmatizing, environment - primary care. Bringing mental and behavioral health care into primary care allows patients to view this type of care as a normal, routine aspect of their overall healthcare plan. This normalization of mental and behavioral health care goes a long way to reduce the stigma associated with these vital services.

Personnel attached to BHIP include: Internal Behavioral Health Consultant (IBHC), a licensed independent mental health provider who offers same day and scheduled appointments at the request of the PCM; Behavioral Health Care Facilitator (typically a nurse) who at the request of the PCM, contacts the patient via phone to check in on psychotropic medication treatment adherence; and, the External Behavioral Health Consultant (EBHC), a licensed independent psychiatric prescriber who is located remotely but remains readily available to the MHP team for consultation. The successful completion of a formal training program is required for all three types of providers.

All medical Homeports throughout the Navy with 3,000 or more enrolled patients are funded to have an IBHC in their clinic. Some are active duty providers, but most of these providers are contractors, and are typically a psychologist or social worker. Appointments are usually 30 minutes and focused on a particular presenting problem as it currently impacts the patient's health and well-being. An in-depth assessment of this problem by the IBHC is followed by the collaborative planning of the patient's intervention plan. At the end of an IBHC appointment, patients depart with an intervention plan designed for implementation outside of the appointment. Patients are referred by the PCM or self-request, and tend to average one or two appointments with the IBHC per episode of care.



If the IBHC or the patient feel the patient would benefit from more comprehensive mental health care, appropriate referrals are made. Similarly, if patients receiving specialty mental health care are considered stable by their provider, then these patients are appropriate for transfer to primary care, to be seen by the IBHC. IBHCs provide primary level mental and behavioral health care, and thus do not do medical boards, fitness for duty evaluations, DONCAFs, or Temporary Disability Retirement List evaluations. Patients requiring these types of services are referred to specialty mental health clinics.

Since the implementation of the BHIP model, several program benefits have been noted, including improved readiness. Oftentimes, active duty premorbid behavioral health concerns are identified and ameliorated prior to reaching clinical levels that impact members and their ability to complete the mission. Healthcare costs have decreased due to decreasing the number of network referrals to the civilian community for specialty mental health services. Population health has improved due to services being open to all MHP enrollees, and the experience of care has been enhanced. Overall, patients benefit from having access to an on-demand mental health provider and all interactions with BHIP personnel occur in the Medical Home Port, thereby reducing potential barriers to patients accessing the care (and reducing stigma), and increasing coordination of care with the PCM. BHIP training is now part of the psychology internship training curriculum and many interns will have the opportunity to learn more about the treatment model and work as an IBHC.

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CDR Arlene Saitzyk receives the touted Longacre Award at AsMA Honors Night! The Longacre Award is given annually for outstanding accomplishments in the psychological and psychiatric aspects of aerospace medicine. CDR Saitzyk is the 2016 Aerospace Psychologist of the Year.



LT Nicholas Petikas, clinical psychologist at Wounded Warrior Battalion, receives the Starfish Award for his valiant efforts in supporting patient care, June 23. Petikas placed himself in harm's way, while overseeing the safety of a Marine with suicidal ideations. Petikas worked directly with the base Provost Marshal's Office to deescalate the situation, while preserving the patients' integrity. The actions of Petikas directly resulted in the patient receiving the care that he needed. The Starfish Award is presented to Naval Hospital Camp Lejeune staff who through exemplary acts demonstrates commitment to the Navy's core values — honor, courage and commitment.

USING TECHNOLOGY FOR CLINICAL EVALUATIONS

LCDR Shawna Chee, LCDR Daniel De Cecchis, CAPT (ret) William McDonald

Aerospace Medicine is a highly specialized field of medicine committed to the safety of the flying public. Medical standards, agreed upon internationally, state that aviators suffering from any medical condition that jeopardizes flight safety (including mental illness) should be restricted from flying duties. It is currently recommended that aviation personnel be evaluated by medical providers with specialized training in aviation mental health issues, especially for the more common and detectable mental health conditions and life stressors that can affect pilots and flight performance. Given the heightened need of improving the awareness and identification of pilot mental health issues, specifically in a military aviation environment, the Naval Aerospace Medical Institute's (NAMI) Department of Psychiatry developed an easily accessible, comprehensive evaluation through video teleconference (VTC) protocol to assist flight surgeons and patients currently stationed across the nation and overseas, in specific aeromedical-focused psychological assessment.

This process started when the NAMI Psychiatry Department was approached by a flight surgeon stationed overseas with a request to perform a comprehensive aeromedical psychiatric evaluation of a senior tactical jet pilot who had experienced symptoms suggestive of anxiety in the aftermath of an in-flight hypoxic event. Prior to January of 2016, in order for NAMI to perform such an evaluation, the pilot's command would have had to send him to Pensacola, FL, literally halfway around the world. This in-person evaluation would have cost the command approximately \$5,000 and it would have meant that the pilot would be away from work for seven to ten days, a significant burden on the command and impact on the mission.

In January of 2016, however, NAMI Psychiatry began offering remote special duty evaluations via the BUMED-approved VTC initiative. NAMI Psychiatry currently uses the CISCO® Jabber network camera. Six cameras were provided at no cost to NAMI Psychiatry by the Navy Medicine East Program Manager for Tele-Health. Three of these cameras were installed in the NAMI Psychiatry Department. These cameras provide the fleet flight surgeons and other medical providers with real-time video access to the unique aeromedical psychiatric expertise available only at NAMI. Three other CISCO® cameras are available for loan to operational medical providers and provide a real-time, point-to-point solution for the operational medical provider to connect from the comfort of their Navy Medicine domain computer.

Soon after its introduction, the program gained momentum, and the process was codified in NMOTCINST 6300.4 dated 24 June 2016 when the former Navy Medicine Operational Training Center (NMOTC) CO, CAPT Kane, expanded the model to allow all NMOTC detachments to conduct remote special duty evaluations using the CISCO® Jabber cameras that are available at no cost from the U.S. Army Medical Information Technology Center (USAMITC). Of note, while this program is designed to increase access to specialty evaluation services and decrease costs incurred by the command and the service member, there are several studies that demonstrate efficacy when comparing this modality to the traditional "in-person" evaluation. "Remote psychotherapeutic interventions have been shown to produce clinical outcomes similar to traditional face-to-face (FF) interactions, and diagnosis via telemedicine has demonstrated comparable accuracy when compared to the [face to face] evaluation" (Loh, Donaldson, Flicker, Maher, & Goldswain, 2007).



As well, "Research comparing clinical diagnostic interviewing conducted via VTC and traditional face-to-face conditions has suggested generally good agreement in a variety of conditions, including dementia and cognitive impairment of various causes as well as neuropsychiatric groups and healthy controls" (Barton, Morris, Rothlind, & Yaffe, 2011). Notably, just recently at Naval Health Center Pax River, Navy psychologist LT Crosby and Nurse Corps officer LT Davis, along with Walter Reed National Military Medical Center (WRNMMC) psychologist LT Jackson and USPHS psychologist CDR Reed implemented a joint service telepsychiatry pilot program between the two sites. Six WRNMMC psychiatrists are credentialed at NHC Pax River, and are seeing Pax River patients virtually. Prior to this program, Pax River patients had to drive over two hours to WRNMMC or an hour to Andrews Air Force Base for psychiatric care.

In the case above, of the pilot who suffered the hypoxic event, the aviator received a clean bill of health from the NAMI Psychiatry Department, and returned to duties involving flight the day after the evaluation. Following that "proof of concept" event, the NAMI Psychiatry Department now invites referring medical providers to contact our department (usn.pensacola.navmedotcnaefl.list.NAMI-Psychiatry@mail.mil) to discuss this option as a means to reduce the command's operating costs, decrease the wait time for an evaluation, and ultimately support the needs of the fleet. Future goals include offering neuropsychological screening evaluations through this venue as well. Ψ

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HAPPY BIRTHDAY AMERICA!



LT Michael Polito gets folks moving at Naval Health Clinic Hawaii! As Chair of the Command Morale, Welfare, and Recreation Committee, he organized the Inaugural Red, White, and Blue Fun Run/Walk, with over 54 participants and 20 volunteers. Get fit Hawaii!

NAVY CHILD PSYCHOLOGY

CDR DAVID M. BURKE

It's likely that when most psychologists think about joining the military, they do not envision treating or evaluating children and adolescents. It's only after immersing ourselves in Navy Medicine we recognize that in addition to our primary mission of supporting the operational forces, we also provide substantial support to dependent family members. Time and experience have taught us that when we provide proper care for families of Sailors and Marines, they are much more mentally engaged and effective in their roles.

Perhaps one of the strongest selling points to the Navy Psychology Pediatric Fellowship Duty Under Instruction (DUINS) is the opportunity to step out of your typical role for a year and train at any one of a number of world class children's hospitals. Many of the top children's hospitals in the country (e.g., Boston Children's, Children's Hospital of Philadelphia, Children's Medical Center Dallas) have been involved in the training of active duty providers and have made considerable accommodations for us to enter their training facilities and tailor a program to meet the needs of military families. With some variation, most pediatric programs have a combination of emphasis on evaluations (e.g., autism, ADHD, cognitive, emotional) along with clinical interventions and skills development.

Like all DUINS opportunities, the role of training is to fill a critical need, and the Pediatric Fellowship in Psychology is no exception. Navy Psychologists who receive postdoctoral training in child psychology complete a follow-on utilization tour in Japan, where they are typically placed in a supporting role for the Educational and Developmental Intervention Services (EDIS). EDIS is a department within the Directorate of Medical Services (DMS) at the hospital, but the work is largely conducted in Department of Defense Educational Activity (DoDEA) schools throughout Japan, and is one of the only congressionally mandated programs at our overseas Navy hospitals. The EDIS programs primarily exist overseas due to the limited availability of community resources and pediatric specialties to support the school districts. Although the work is mostly accomplished in the school setting, EDIS's federal mandate and the work of child psychologists receive considerable command visibility.

While completing one's utilization tour as a pediatric psychologist, there are also opportunities to work with adults in outpatient mental health. When LCDR Michael Domery (a recent Pediatric Fellow) came to Yokosuka, Japan for his utilization tour last year, the command determined the need was greater in outpatient mental health vice EDIS, so he was placed full time in the Mental Health Department. As the Department's sole Child Psychologist, he conducts evaluations for the school, but also provides much needed clinical intervention services for both children and adults. He also serves as the current Department Head - the placement was optimal as LCDR Domery chose a fellowship with a greater clinical (as opposed to evaluative) emphasis.

There has been a common misconception that once you follow the pediatric track you are "pigeon-holed" into child work for the rest of your career. This is a myth. The reality is that you are required to fulfill a utilization tour in Japan and then will likely go back to adult work at your follow-on command. However, you can retain the added advantage of maintaining clinical privileges in both adult and pediatric work, making you an asset to any new command as you have a much wider scope of capabilities.



That being said, it's unlikely you will continue to do a great deal of child work upon return to CONUS as the demand for adult providers for our active duty population is high, and children and adolescents can more easily be referred to the network where there is a multitude of resources. In contrast, the Pediatric Fellowship is meant to provide critical resources for our families in locations where they would not otherwise have access (i.e., OCONUS).

For me, the most exciting part of this path has been the opportunity to step out of my comfort zone, retrain with a completely different population, and broaden my scope of care. The fellowship was challenging; going into a student status after being licensed for ten years was humbling but it proved to be an amazing personal and professional experience as I was faced with rethinking many of my approaches as a clinician. I should also say that one of my concerns going in was that it would somehow stall my career, but that has proven completely unfounded. I have had access to the same leadership opportunities I would have had if I had reported to Naval Hospital Yokosuka as an adult provider. The only difference is that my clinical obligation remains with EDIS regardless of my current leadership role at the command. All in all, the work as a Child Psychologist has been incredibly rewarding, and I find that I enjoy it even more than I thought I would. This role has given me a much greater appreciation for how a child's struggle impacts the family and the service member, and therefore my work seems as tied to the fleet as any job I've held before. Ψ



LT Courtney Ann Pollman-Turner strongly representing clinical psychology with the All Navy Women's Triathlon Team!

GOOOOAAAALLL!!

LT Pascetta and the clinic soccer team, Scalawags FC, of MCAS Cherry Point celebrate an undefeated season!



SPOTLIGHT ON ETHICS: A TALE OF TWO CLIENTS

LT ALLISON CLARK

As military psychologists, we often find ourselves balancing important ethical obligations, because in clinical roles we provide services for both the patient and the Department of Defense, a situation often referred to as “dual agency.” As my internship supervisor repeatedly said, “You always have two clients in the room.” Dealing with dual agency is often one of the first ethical conundrums we encounter in our line of work.

Case

It's a Wednesday morning at a large military treatment facility, and my first patient is a Marine Sergeant, who voluntarily presented for psychological evaluation at the suggestion of his command's medical officer. He agreed to the terms of the informed consent discussion, confirming understanding that my role involves assessing both treatment needs and fitness for duty. His line leaders did not express concerns about his functioning, and he has a history of successful military performance. However, collateral information from the medical officer indicated he had been experiencing delusions and auditory hallucinations since age 15, a decade before joining the service. He reported having coped with his symptoms through religion, avoidance of stimuli that trigger ideas of reference, and strict adherence to order and discipline. This has helped allay significant impairment through his six years of military service, and he denied experiencing acute distress at the time of the interview. He reported his symptoms to his unit only to show solidarity with a peer suffering from mental health problems. Upon sharing the details of his condition with the medical officer in his unit, he was scheduled for an acute evaluation with me. The psychosocial history I gathered revealed that despite identified psychotic symptoms, he has maintained insight into the illness, as well as some degree of control over the positive symptoms (e.g., he was able to stop the voices from including his wife as a target of obscene statements). There were no signs of malingering, as he expressed a desire to attend an upcoming non-combat deployment for financial reasons, and said he looked forward to retiring as a career Marine.

As in all active duty evaluations, I have two tasks: (1) determine a diagnosis and offer treatment recommendations if indicated, and (2) make a recommendation regarding his fitness for the duties of his occupational specialty and deployability.

Related Principles

In cases such as this, it can feel as though a recommendation for separation from service is in conflict with Principle A (Beneficence and Nonmaleficence) of the American Psychological Association (APA) Ethical Standards (APA, 2010), in that it may be in the patient's best interest to maintain his job/income and receive a message from his therapist of hope, trust, and belief in the human capacity for adaptation. If I were acting solely as a patient advocate, I would encourage the patient in the belief that his illness does not make him untrustworthy; notably, his success through six years of service with these symptoms reflects exceptional resilience. Further, knowing that service members speak offline to one another, I am aware of the long-term effects that an unwanted medical discharge might have on mental health stigma. That being said, we must also consider safety of the mission in the community we serve (as well as the safety of the patient himself) in order to most strongly support Principle B (Fidelity and Responsibility). With his reported symptoms, there is a fair amount of risk to the Marine and his unit should he be retained. Thus the conflict between supporting the needs of the patient (to remain in service) and the needs of our client, the command, who requires explicit information regarding the risk involved in maintaining this Marine on active duty, and furthermore, while forward deployed.



As we know, the interrupted sleep schedules, stressful environments, and separation from coping resources inherent to deployment can worsen psychotic illnesses, leading to a considerable decrease in mission safety. On one hand is the sadness I feel in recommending separation from service, my acknowledgement of the effects an unwanted separation will have on mental health stigma, and the desire to align with the patient's wishes (beneficence to the patient). On the other hand, I have my obligation to ensure mission safety and my knowledge of the risks associated with psychotic disorders (beneficence to the client, and fidelity/responsibility).

Decision Making Process

When confronted with such a dilemma between Principles A and B, a recommended first step is consultation with other military psychologists and the relevant instructions (DoDI 6130.03; DoDI 6490.07). These instructions provide guidance regarding Department of Defense regulations related to mental health diagnoses that limit one's fitness and suitability for service in the U.S. military. I consulted with two civilian psychologists and one active duty psychologist; all of the feedback reflected the fact that a feeling of disappointment in a decision does not indicate a poor or incorrect decision. Another suggestion in these types of cases is to consider the use of psychological testing to bolster strength in the diagnosis and recommendation. This expands the data points beyond interview and collateral information, and may assist the patient with acceptance by using therapeutic assessment strategies.

I clearly recall how difficult it was for me to consider not recommending continued service, as he very much wanted to stay in the Marine Corps. However, with the diagnosis of Attenuated Psychosis Syndrome, I recommended separation from service because of my duty to promote the safety of the unit. I felt compelled to advocate for the leaders and peers to whom this Marine is accountable. I believe this mission-conscious decision also protects the service member, as he could be harmed if in the high stress environment of deployment his symptoms increase and overwhelm his current coping strategies and compromise functioning. While I cannot identify one ethical principle as more important than any other, in this case, safety of the unit's mission overrode my responsibility to align with the patient's wishes. I made the choice most in line with Navy Medicine's mission to preserve the fighting force, this time by ensuring safe and healthy unit functioning as a whole rather than trying to salvage a well-trained Marine.

The fact there are always two clients often affects our decisions as military psychologists. We continually strive to deliver empathic and effective mental health care, and yet this also sometimes includes making recommendations to commanders that may be painful to others and even to ourselves as compassionate caregivers. While acknowledging the challenge of making such recommendations greatly impacts others' lives, we can also take comfort in the ultimate benefit that a sound decision is likely to have for both the Department of Defense and the individual. Ψ

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WHAT DO YOU DO WITH A DRUNKEN SAILOR?

LCDR DAVID LOOMIS & LT SARAH BROWER

“Farewell to foreign shores, we sail at break of day. Through our last night ashore, drink to the foam, until we meet once more. Here’s wishing you a happy voyage home.” – *Anchors Aweigh*

Sailors have long held a reputation for quaffing copious libation ... or drinking a lot. What do you do with a drunken sailor? According to the sea shanty, “Drunken Sailor,” you could “put him in a long boat and make him bail her, shave his belly with a rusty razor, tie him to a mast and then you flog him, put him in the guardroom till he gets sober ...” and the stanzas go on.



In the late 1960s the Navy launched its first official alcohol treatment program in Long Beach, CA. The need for substance abuse treatment became apparent with the high rates of drug use among active duty military during and after the Vietnam War. Substance Abuse treatment gained additional momentum in the late 1970s after Betty Ford, who received treatment at a Navy rehabilitation clinic, became a national proponent for drug and alcohol rehabilitation.

Currently, the Navy has 29 Substance Abuse and Rehabilitation Program (SARP) clinics around the world that provide Outpatient, Intensive Outpatient, and Residential treatment, as well as comprehensive treatment for Co-Occurring Disorders, and Continuing Care services. The Bureau of Medicine and Surgery (BUMED) provides guidance on the basic structure of SARP. SARP treatment programs generally utilize a biopsychosocial model to conceptualize substance use disorders, and a multimodal approach to treatment that is grounded in cognitive and behavioral principles and interventions. Overarching treatment goals include (1) establishing patient awareness and acceptance that a substance use problem

exists, (2) identifying potential obstacles that may hinder patients from making positive changes in regard to substance use, and (3) identifying and utilizing interventions to address the identified obstacles to making positive changes.

The American Society of Addiction Medicine (ASAM) has established six criteria or dimensions regarding how substance abuse is assessed and treated. These include withdrawal risk, medical and emotional problems, readiness to change, relapse potential, and recovery living environment concerns that may impact treatment and recovery. When ASAM criteria are used in conjunction with DSM diagnoses, these dimensions help clinicians determine the best level of care for patients, and also provide a framework for developing treatment goals and objectives.

SARP offers four levels of intervention, not including medical alcohol detoxification, which usually occurs on an inpatient internal medicine ward. The lowest level, “Level .5” also known as IMPACT, is a 20-hour psychoeducational course generally recommended for those who show risky behaviors involving alcohol, but who do not meet criteria for an alcohol use disorder. Level 1 is 56-72 hours of outpatient treatment that includes group processing, workshops, and psychoeducation, and is recommended for those with a mild alcohol use disorder. Neither IMPACT nor the Level 1 program are abstinence based, but rather encourage responsible use of alcohol. Levels 2 and 3 are abstinence-based programs recommended for those diagnosed with moderate to severe alcohol or drug use disorders.



Level 2, Intensive Outpatient, is a 112-128-hour program, and Level 3, Residential, is a 35-day program. Residential treatment is offered at only three locations in the Navy (with Naval Medical Center San Diego and Naval Medical Center Portsmouth being the largest programs). Following a Level 2 or 3 treatment, patients attend a two-hour continuing care group once weekly for a period of one year to help maintain sobriety and positive coping skills.

As previously mentioned, SARP offers a comprehensive program capable of serving a co-occurring disorder population, particularly at Level 2 and 3. A team of licensed providers, including psychiatrists, psychologists, social workers, and psychiatric nurse practitioners, meet with patients individually and in groups to help identify and address mental health concerns beyond substance abuse diagnoses.

The majority of the substance use treatment groups are facilitated by substance abuse counselors. Notably, SARP programs employ civilian contractors, federal government employees, and active duty officers, but many of the counselors are actually enlisted active duty military members. Counselors, who must be E-5 or above, attend a rigorous ten-week course in San Diego called the Navy Drug and Alcohol Counseling School (NDACS). These Navy counselors are not Hospital Corpsmen (or more specifically Psychiatric Technicians), but rather come from all different rates, and all possess a desire to become substance abuse counselors. Substance abuse counselors work under the supervision of licensed providers. These licensed independent providers (or the "LIPs") determine diagnoses and recommended treatment level for patients referred for treatment. They meet weekly with patients on their team to review progress and update treatment goals as appropriate, and when necessary, advise commands about patients who are considered treatment failures.

LCDR Loomis serves as the Division Officer for the Outpatient SARP program at Naval Medical Center San Diego, while LT Brower serves as the Assistant Department Head of the SARP program at Naval Medical Center Portsmouth. Both of us are in primarily administrative roles involving staff and program management. A typical day involves addressing unique issues that arise in terms of patient care, command relations, or program improvement. We utilize training as psychologists to help enhance program structure and guidelines, and advise fellow clinicians and counselors on dispositions of patients. We also work closely with commands to get these service members the help they need and return them to the fleet. Our numbers at Naval Medical Center San Diego indicate that 70 percent of patients are able to complete their current enlistment without further alcohol related incidents, and we believe that is representative sample throughout the fleet. So what do you do with a drunken Sailor? Rehabilitate them with an intensive and comprehensive SARP program and wish them a happy voyage home. Ψ

Special congratulations to **LCDR Linda Havens**, the new selectee for the Naval Operational Psychology Fellowship, who was 1 of 35 sailors selected from across the Navy for the Naval War College Junior Leader Forum. Bravo Zulu!



BRAVO ZULU!

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BRAVO ZULU!

CONGRATULATIONS TO OUR PROMOTING PSYCHOLOGISTS!

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BELT UP! LTs Parker (left) and Pascetta (right) receive MCMAP Gray Belt Certifications from from Sgt Terry Paxton of Marine Aerial Refueler Transport Squadron (VMGR-252).

SPOTLIGHT ON HISTORY: KEEP FIGHTING

2LT Jennifer Barry (USAR) and LT Marcus VanSickle (USN)

A young female Marine lieutenant enters your office with a presentation not unlike many patients you have seen before. She is dysthymic, confused, and seemingly lacking confidence and motivation. “Why am I here? I’m not strong enough for this,” she states. The lieutenant’s command has referred her to you out of concern she may not be suitable for continued service. Depending on available time for treatment, past behavioral health history, and your theoretical orientation, multiple theories begin to take shape as you consider how to conceptualize this case. What treatment method may best serve this Marine as well as the greater Marine Corps?

“Let’s go outside and fight. I know you have your tan belt. I’m going to be your meat puppet. I want you to throw me on the ground. Now, see those black belts over there? Go throw them on the ground.” This response is one many of us may never have considered, but it was the response given by LtCol Joseph Shusko (USMC, Ret) to a young lieutenant, brought to his office upon being dropped from The Basic School (TBS). LtCol Shusko is the director of the Marine Corps Martial Arts Center of Excellence (MACE) in Quantico, Virginia. The MACE is responsible for the development of and training in the Marine Corps Martial Arts Program (MCMAP). As the story unfolds, through MCMAP training and consistent mentorship from LtCol Shusko and his wife, the young lieutenant was able to rekindle the confidence and drive that originally led her to seek a commission. She eventually completed the Marine Corps Martial Arts Instructor Trainer Course – a grueling 7-week course only offered at the MACE – and returned to her unit to train other Marines in MCMAP. She ultimately completed a successful and satisfying career in the Marine Corps as a second degree Martial Arts Instructor Trainer.

Intrigued at the lieutenant’s transformation, these authors asked LtCol Shusko what key ingredients underscored his prior student’s success. In psychobabble, his response amounted to Rogerian-style genuineness, behavioral activation, and a shift in core beliefs. In Marine-speak, he simply stated “I showed the Marine I genuinely care for her; I took her out and experienced adversity with her, and I helped her to see what she can accomplish when she puts her mind to it.” A recommendation he makes for all psychologists is to “get dirty.” “We likely won’t listen to you if you don’t know what it’s like to be us.”

MCMAP officially dates back to the 1990s, though it is said to incorporate elements of Marine Corps history from as far back as the Continental Marines whose prowess in close quarters combat aboard enemy ships is legendary.



LtCol (ret) Joseph Shusko instructing students.

The Marines' expertise in sword and bayonet fighting was enhanced during World War I with the addition of training in unarmed techniques designed to inflict maximum damage in the extreme close quarters of trench warfare. Throughout World War II, hand to hand combat remained a necessary skillset utilized by Marines in the Pacific Rim. Early systems such as Combat Hitting Skills, the O'Neil System, and the Marine Raiders' hand-to-hand program were effective and lethal. It is believed that these Marines, exposed to fighting forms such as judo and karate, integrated and shared these Far East martial arts with fellow Marines back home. As the Corps continued to refine martial arts training from the world wars through the Vietnam War, complementary training programs in leadership and character development also began to take shape. It is from these early programs that the Corps' modern day aspiration to its core values of honor, courage, and commitment first emerged.



During the post-Vietnam era of the 70s and 80s, professional military education and leadership development programs continued to flourish. The importance of combatives training, however, was neither forgotten nor neglected. The Linear Infighting Neural Override Engagement (LINE) system was developed in an attempt to standardize a close combat system for the Marine Corps. The LINE system, MCMAP's most recent predecessor, grew and changed over the course of the next 20 years. In 1996, 10 subject matter experts (SMEs) representing a variety of martial arts disciplines came together to review the LINE system, as well as elements of other past Marine Corps fighting programs. Together these SMEs developed a unified, comprehensive martial arts program known as the Marine Corps Close Combat Program.

By 1999 Commandant James L. Jones was sharing his vision for a formal Marine Corps Martial Arts Program, which spurred the research, testing, and review necessary to evolve the Close Combat Program into an innovative and comprehensive training paradigm designed to enhance the total Marine. Streamlining combat training by incorporating proven elements of the Corps' leadership and character development programs, MCMAP's success is a study in integration. MCMAP students learn more than the martial arts skills and close combat training techniques honed over the Corps' 241-year history. They learn these skills while simultaneously developing themselves as leaders who ascribe to a higher set of values: those of the Ethical Warrior.

As behavioral health providers, our professional ethics generally prohibit us from physically fighting our patients, so LtCol Shusko's creative and supportive method to building up the lieutenant's confidence and trust may not be a one-size-fits-all approach. A full comparison between psychological and battlefield ethics is beyond the scope of this article, however, foundational similarities between MCMAP training and therapy are readily notable. Consistent with the therapeutic application of positive psychology principles, LtCol Shusko's intent and unique utilization of MCMAP training is designed to build a service member's resilience and grit, an outcome he readily observed in a number of amputation Marines who have worked at the MACE.

MCMAP is built on a 3-pronged framework of physical, mental, and character disciplines. The physical discipline consists of three main components: fighting techniques, combat conditioning, and combat sports. An inclusive combat system, MCMAP covers the four elements of the fighting component: rifle and bayonet, edged weapons, weapons of opportunity, and unarmed combat.

The mental discipline is focused on teaching tactical and technical proficiency – the art of war – and incorporates a professional reading program, Marine Corps Basic Skills Training (MBST), decision making training, the study of war history, tactics and techniques of maneuver warfare, and the study of Marine Corps history, customs, courtesies and traditions. Character discipline is the spiritual aspect of a Marine's development, incorporating the Core Values and Leadership Traits and Principles, and focusing on the human dimensions of combat. The program seeks to breed ethical warriors who are confident, self-disciplined, self-aware and focused on defending others first and foremost.

The three disciplines instill the fearlessness and fighting spirit necessary for our warfighters to succeed on the battlefield, indoctrinating Marines with the mental sharpness, grit, and intellectual acuity necessary to make and execute split-second decisions, along a continuum of force, while in danger. Perhaps the most important discipline, character, reinforces the continued development of resilience and ethical decision-making that are in keeping with the core values of honor, courage, and commitment. Marines only "belt up" when they have sufficiently demonstrated the fighting skills necessary to graduate to the next level, as well as the maturity, judgment, and other character traits expected of a warrior entrusted with such a skillset.

The authors of this article represent a wide scope of MCMAP training, from tan belt (2LT Barry) to brown belt instructor (LT VanSickle). Each stage of training teaches skills from all three disciplines so that Marines at every

level of training receive well-rounded and generalizable lessons. The MACE headquarters, located on the Marine Corps' TBS grounds, contains a growing Raider Museum, courtesy of LtCol Shusko's dedicated efforts to preserve Raider history and celebrate its contribution to modern day Marine training. A knowledgeable and earnest tour guide, LtCol Shusko readily shows priceless Marine heirlooms and photos while regaling visitors with tales of Marine Raider history. "Don't underestimate the skills you just learned" he told 2LT Barry after testing for and earning her tan belt. "The tan belt curriculum is based entirely upon



the hand-to-hand combat skills taught to Raiders headed into World War II. I promised the remaining Raiders we would never change that, and we haven't."

The sense of love and respect for Marine Corps history, tradition, and esprit de corps is palpable at the MACE, whose instructors train service members from all branches of the armed forces as well as numerous foreign militaries. Indeed, LtCol Shusko's theory about sweating and "getting dirty" together seems to apply across a wide variety of cultures. As the training becomes increasingly difficult, students are challenged in unimaginable and life-changing ways. Ultimately, they learn to believe in themselves and trust others, knowing without a doubt that they can survive, and even grow, from any challenge life tosses at them. An immersive study in Marine Corps culture and a force multiplier for psychological health and resilience, psychologists would do well to learn about MCMAP. We would do even better to venture forth from the confines of our offices and truly "get dirty" with our Marines. Ψ